waterfordplace
Cancer Resource Center

Medical Release Form

To Be Completed by Participant:

Date: _____ Participant Name:_____Birthdate: _____

I,_____authorize my physician to release my personal health information to Waterford Place Cancer Resource Center for the purpose of participation in the movement and yoga programs, massage therapy, oncology facials, craniofacial therapy and/or acupuncture.

Patient Signature: _____ Date: _____

To Be Completed by Physician:

Movement and Yoga Programs consists of:

- 50 minute, Instructor led muscular strength / endurance, balance and flexibility training

I approve of the aforementioned patient participating in Waterford Place Cancer Resource Center programs. Please list any specific restrictions:

_____

_____

Complementary Therapies (Oncology Massage, Oncology Facials, Reflexology) consists of:

- Light, 40-45 minute sessions for stress reduction

I approve of the aforementioned patient participating in Waterford Place Cancer Resource Center programs. Please list any specific restrictions:

_____

_____

Physician Name (print): _____

Physician Signature: _____ Date: _____

Medical Office Name / Affiliation: _____

Medical Office Phone Number: _____

PLEASE FAX COPY TO WATERFORD PLACE CANCER RESOURCE CENTER AT 630.800.1768